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ABSTRACT

Some mental health experts have suggested that particular subgroups of the chronic mentally ill may be especially vulnerable to human immunodeficiency virus (HIV) infection. Patients with mood disorders (manic type), schizophrenia, and dual diagnosis of either disorder with substance abuse are considered at high risk for HIV infection, as are psychiatric patients with poor judgment, hypersexuality, and impulsivity, characteristics that interfere with practicing safer sexual and/or drug-related behaviors. A major problem is how to adapt HIV prevention programs to take into account these clinical characteristics. Given the types of cognitive deficits that many psychiatric patients have, it may be useful to adapt HIV prevention efforts for this population by: (1) not providing too much information at one time; (2) being explicit; (3) keeping explanations simple; (4) using concrete examples of future interpersonal situations the patient is likely to encounter; (5) using repetition; (6) applying the guidelines of being concrete, simple, and repetitive by developing group exercises that apply to the principles of safer sex; (7) using humor; and (8) developing a supportive alliance with the patients before providing HIV information or attempting behavioral change. A psychoeducational model may be useful. Before any type of prevention program can be implemented, mental health professionals must not only master basic HIV information, but must become comfortable talking about sex with their patients. (NB)

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Cognitive Deficits in Psychiatric Patients: Constraints on HIV Prevention

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A decade into the AIDS epidemic, no large-scale research has yet been conducted to document that HIV poses a *more* substantial risk to the chronic mentally ill than it does to the general population. But in two small surveys last year that performed random and anonymous HIV tests on psychiatric inpatients at three New York City hospitals, an infection rate (5.9%) was found that is double the infection rate found in the general population in New York City (2.9%) [cited in Goodman (1991)]. In addition, cases of full-blown AIDS among the chronic mentally ill are now being reported with some regularity (Harwath et al., 1989; Cournos et al., 1990), and mental health professionals are finally beginning to prepare for the care of increasing numbers of HIV-infected mental patients (Britt, Hagman, Franzione, & Ferran, 1991). In short, certainly we know that the chronic mentally ill are not immune from HIV, which seems to have been the attitude of many mental health professionals during the first half of the AIDS epidemic.

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Some mental health experts have suggested that particular subgroups of the chronic mentally ill are especially vulnerable to HIV infection. Cournos et al. (1990) have argued that patients at greatest risk to HIV are those diagnosed with mood disorder (manic type), schizophrenia, and dual diagnosis of either disorder with substance abuse. Carmen and Brady (1990) have noted that psychiatric patients at greatest risk share three characteristics: (a) poor judgment, from either impaired cognitive functioning or affective instability; (b) hypersexuality; and (c) impulsivity. These characteristics seriously interfere with acquiring and practicing safer sexual and/or drug-related behaviors that can greatly reduce the probability of HIV transmission.

A major problem, then, is how to adapt HIV prevention programs to take into account these clinical characteristics. Perhaps the most problemmatic feature in the clinical profile described by Carmen and Brady is the cognitive deficits of many chronic mentally ill patients. After all, a number of individuals in the general population whom we would not label as mentally ill are hypersexual and also are impulsive. We obviously need to address those characteristics in designing HIV prevention programs. But the unique challenge of the mentally ill is that many suffer from thinking disorders and have severe deficits in processing information, deficits that not only interfere with educational efforts but in addition may exacerbate impulsivity and hypersexuality.

Briefly, schizophrenic patients have been shown in research on information processing to have difficulty in selecting relevant stimuli and ignoring irrelevant stimuli (Nuechterlein & Dawson, 1984). These deficits result in poorer performance on tasks that require them to sustain attention on a specific task, or to shift their attention quickly and flexibly, as on tasks involving sequencing and concept formation. Some researchers argue that the basic deficit in schizophrenia, which probably has an organic or biochemical basis, is a vulnerability to being overstimulated attributable to an abnormally high baseline level of arousal (Anderson, Reiss, & Hogarty, 1986). Cognitive research with schizophrenic

patients has shown that as informational overload increases, performance deteriorates rapidly (Nuechterlein & Dawson, 1984). Apparently the patient is easily flooded with information that cannot be processed in any coherent or rational way; such overload may contribute to hallucinations, delusions or bizarre behaviors directed by the faulty thinking. This laboratory-based research supplements our longstanding clinical experience that schizophrenic individuals think in the most concrete ways and cannot easily consider the longer term consequences of their behavior, considerations that are simply too abstract. This lack of ability to think futuristically not only interferes with the patient's taking antipsychotic medication in order to prevent future relapse, but also interferes with practicing safer sex in order to avoid the life-threatening illness of AIDS. In short, these deficits reduce the functioning of schizophrenic patients in serious ways. Moreover, in their review of the literature, Nuechterlein and Dawson (1984) found considerable evidence that the cognitive deficits are present prior to an actual psychotic episode and remain with the patient in remission from the psychotic symptoms.

What then are the implications of these cognitive deficits for designing HIV prevention programs for this population? I'm sure many of you have heard the story about the schizophrenic patient, who after attending a safer sex workshop, tells the counselor that he is indeed practicing safer sex: beside his bed is now a banana fitted with a condom.

Given this review of the types of cognitive deficits many of these patients have, some suggestions are offered for adapting HIV prevention efforts to this population:

a) Do not provide too much information at once. One-shot workshops are not sufficient for patients to integrate AIDS 101 information and to begin safer sex practices. A series of short discussion groups is a more appropriate format. No session should extend longer than 20-30 minutes, since the attention span of schizophrenic patients is so short and they are far too easily overloaded with information.

b) Be explicit. In addition to using the proper terminology, also use street names for sexual acts, sexual organs, and drug paraphernalia. Instead of using a banana to illustrate the proper use of a condom, use a dildo. Better yet, use videos to illustrate condom use.

c) Keep it simple. The biological action of HIV is very complicated and not fully understood from medical researchers. Do not go into complex detail about HIV. What is presented should be accurate, of course, but it is not necessary to present a complete biological explanation of HIV in order to alert patients about how they need to change their behavior.

d) Use concrete examples of future interpersonal situations the patient is likely to encounter. As individuals begin to integrate safer sex information into their behavior, they have to learn how to discuss and negotiate safer sex practices with their partners. Remember that most patients have severely limited interpersonal skills. Negotiating safer sex can be difficult for those of us who are not mentally ill; imagine what it must be like for these individuals. Again, videos can provide models, and simple role-play exercises can be extremely useful.

e) Use repetition. It is necessary to repeat critical information over and over. Do not believe that simply because you have presented the information once or twice that patients have heard it.

f) To apply the guidelines of being concrete, simple and repetitive, develop group exercises that apply the principles of safer sex. For example, make up a deck of cards with different sexual practices written on them. Have the group decide which pile to place them in: high-risk, low-risk, no-risk.

g) Use humor. Mental patients are just as uptight talking about sex as many of the rest of us. Lighten up the discussion with humor, and use cartoons or jokes.

h) Develop a supportive alliance with the patients before providing HIV information or attempting behavioral change. Like so many individuals who are not mentally ill, these patients do not want to deal with HIV/AIDS; they prefer to keep it at arm's length. They may believe they are not vulnerable to the virus, or they do not want to think about death. In permeating this resistance, it is better initially to join with it--elicit discussions about what the patients currently believe about HIV/AIDS, their prejudices about people infected, and their anger that they now have to think about these uncomfortable ideas. After a supportive alliance exists, the facts can then be introduced.

The last suggestion leads to the question of who should provide HIV prevention training for this population -- the mental health professionals who already work with the chronic mentally ill, or AIDS health educators? The problem, at least in my experience, is that the professional careproviders (psychiatrists, psychologists, social workers, mental health technicians) are often not comfc able dealing with HIV/AIDS. And the health educators who provide AIDS 101 to many in the general population do not know much about chronic mental illness. The two groups of professionals have much to learn from and offer one another.

Even if outside health educators provide the basic AIDS 101 information to the patients, on-site counselors must then provide support and followup. Because of its ongoing alliance with the patient, the treatment team is in the best position to provide support as patients change to low-risk behaviors. A successful prevention program will, in fact, get participants aroused and anxious about HIV and about what kind of sex is safe and what kind is not. It is imperative to have adequate followup, so that when a patient has an anxiety attack later after the health educators have gone home, there is staff on site who

are comfortable dealing with the aftermath. We also know from research on other health behaviors the importance of peer influence (Taylor, 1986). It is possible that the staff can organize support groups for patients to continue discussions about HIV.

Before any type of prevention program can be implemented, mental health professionals must not only master basic HIV/AIDS information but must become comfortable talking about sex with these patients. For the last year I have been a consultant to residential care agencies for the chronic mentally ill who are attempting to educate staff about HIV/AIDS. These staff are already overburdened with caring for the chronic mentally ill; they are frequently resentful now having to deal with HIV in their population. If the staff is to be enlisted in an HIV prevention program, obviously they must be trained as well, not only in basic AIDS 101 information but in confronting their own sensitivities.

A suggested model for working with chronic mental patients around issues of HIV/AIDS is psychoeducation, a model that has achieved past success with this population (Strachan, 1986). Psychoeducation is not therapy, but it is more than simply providing information. Psychoeducation provides (a) factual information in a straightforward and nonblaming manner, (b) social support from peers and professionals, and (c) training in more effective coping skills (Tunnell, et al., 1988). Unlike the traditional family psychoeducation model, however, HIV prevention programs are best directed to the patients themselves since the high-risk behaviors are more matters of personal responsibility and because many patients who need HIV/AIDS education may not be closely involved with their families. The premise in working actively with patients is that they will be more likely to behave responsibly if offered direct and accurate information on HIV/AIDS, are taught specific ways to change their behaviors, and are provided with social support to change. The social support must come from both the on-site treatment team and from other

patients. It may be helpful to organize psychoeducational support groups for patients as they begin to integrate HIV/AIDS information into their behavioral practices.

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